DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

Wrasman

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

RECEIVED
JUL - 1 2004

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

1. TRANSMITTAL NUMBER: 04-07

2. STATE: Alaska

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

4. PROPOSED EFFECTIVE DATE
April 1, 2004

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 441.50; 42 CFR 440

7. FEDERAL BUDGET IMPACT:
a. FFY $0
b. FFY $0

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:

Attached Sheets to Attachment 3.1-A, Page 4a and 5, and 6 (PHI)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:

Attached Sheets to Attachment 3.1-A, Page 4a and 5, and 6 (PHI)

10. SUBJECT OF AMENDMENT:
Technical clean-up of limitations for Diagnostic, Screening, Preventive, and Rehabilitative Services.

11. GOVERNOR'S REVIEW *(Check One)*:
☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Does not wish to comment

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Jerry Fuller

14. TITLE:
Alaska Medicaid Director

15. DATE SUBMITTED:
June 28, 2004

16. RETURN TO:
Alaska (04-07)
Approved: 09/23/04
effective: 04/01/04

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: JUL - 1 2004

18. DATE APPROVED: SEP 23 2004

PLAN APPROVED – ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: APR - 1 2004

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME: Karen S. O'Connor

22. TITLE: Associate Regional Administrator
Division of Medicaid & Children's Health

23. REMARKS: Pen & Ink changed authorized by the State on 9/16/04
POSTMARK: 6/29/04 Juneau

FORM HCFA-179 (07-92)

Description of Service Limitations

12 c. Prosthetic devices are provided upon a physician's order.

12 d. Eyeglasses are provided to recipients in response to an initial or change of prescription, or as a replacement of a lost or destroyed pair of glasses. Tinted lenses are not covered unless medically necessary. Contact lenses are not covered except for specific medical conditions. Tinted lenses and contact lenses must be prior authorized. Eyeglasses are purchased for recipients under a competitively bid contract.

13. **DIAGNOSTIC, SCREENING, PREVENTIVE, REHABILITATIVE SERVICES:**

a. Mammography coverage is limited to diagnostic mammograms necessary to detect breast cancer.

b. Screening mammograms are covered at the age and frequency schedule of the American Cancer Society, as provided in state statute.

d. Rehabilitative Services are limited to the following:

(1) Mental Health Rehabilitative Services

(i) The following services are available for children under 21 years of age with an appropriate mental health diagnosis resulting from an EPSDT screen or a mental health assessment:

(A) Crisis Intervention Services, which consist of medically necessary reimbursable services below during an acute episode, including such services as assessment, psychotherapy, and medication management, limited to 22 hours in a calendar year and no more than one hour per day unless prior approval is granted;

(B) Family, individual, or group psychotherapy, with an overall aggregate limit of 10 sessions in a calendar year unless prior approval is granted;

Description of Service Limitations

approval is granted by the division or its designee; and providers must be approved by the Department of Health and Social Services. Family Support Services (Supplement 1 to Attachment 3.1-A) are limited to 15 hours per month, 180 hours in a calendar year unless prior approval is granted.

(ii) For adults who have been found in a treatment plan signed by a physician or a mental health professional clinician to need:

(A) Psycho-Social Development (or "day treatment"), the strengthening of behavioral, intellectual, and emotional skills necessary to regain independence, to a maximum of four hours per day, 3 days per week, and no more than 240 hours in a calendar year; and

(B) Intensive Rehabilitation Services, consisting of one or more of the services of (i) (A) through (F) above, is limited to institutional discharge program participants; the limits of (i)(J), above also apply.

Providers of these services must be approved by the Department of Health and Social Services. Client Support Services (Supplement 1 to Attachment 3.1-A) are limited to a maximum of 15 hours per month and 180 hours in a calendar year.

(2) Alcohol and Substance Abuse Rehabilitation Services:

(i) For both children and adults who are found in a treatment plan to need substance abuse services:

(A) Assessment and Diagnosis, including psychiatric assessments, psychological testing and evaluation, and psycho-social assessments, to a maximum of four hours per assessment and diagnosis;

(B) Outpatient Services, consisting of individual, group, or family counseling, care coordination, and psychosocial development services, is limited as specified in C-G, below;

(C) Intensive Outpatient Services, a more intensive level of outpatient services for more acute patients, at a minimum of 3 days or evenings per week, 8 hours per week, but not over 12 hours per week for a total of 8 consecutive weeks, unless prior approval is obtained for more hours;

(D) Counseling Services, including individual, group, and family counseling, not to exceed 6 50-minute sessions each in any one month and group therapy not to exceed 4 90-minute sessions in any one month, with an overall aggregate limit for all counseling of 10 sessions per month, to be exceeded only after prior authorization;

(E) Intermediate Services, outpatient services provided to patients requiring a residential level of care, consists of counseling, care coordination (Supplement 1 to Attachment 3.1-A), and psycho-social development services, to a maximum total of 10 hours per week.

(F) Pyschosocial Development Services, ("day treatment"), which are services designed to improve or restore the patient's behavioral, emotional, and

Description of Service Limitations

(C) Intake Assessment, a systematic evaluation of status and history, limited to 3 hours per assessment and no more than 1 assessment per admission, unless prior approval is granted;

(D) Medication management, limited to one visit per week for the initial month and once per month thereafter, unless medical justification exists for greater frequency, and no more than 15 visits in a calendar year unless prior approval is granted;

(E) Psychiatric assessment, a systematic evaluation by an MD or psychiatric nurse practitioner, limited to four per recipient in a calendar year unless prior approval is granted;

(F) Psychological testing and evaluation by a psychologist or psychological associate, must be prescribed in an assessment and is limited to 6 hours per recipient in a calendar year, except neuro-psychological testing and evaluation is limited to 12 hours in a calendar year upon prior approval;

(G) Home-based therapy, otherwise-reimbursable mental health services such as psychotherapy, when found necessary by an interdisciplinary team, (IDT) and limited to 100 hours in a calendar year unless prior approval is granted;

(H) Activity therapy, including rehabilitative teaching of life skills, when found necessary by an IDT, and limited to 140 hours in a calendar year unless prior approval is granted;

(I) Day Treatment Services, consisting of psychotherapy and/or activity and home-based therapies, when found necessary by an IDT, and limited to 30 full or 60-half days of service in a calendar year, unless prior approval is granted;

(J) Intensive Rehabilitation Services, consisting of one or more of the services above, when found to be necessary by an inter-departmental team, and limited to 90 days unless prior approval is granted;

(K) Medication Administration Services, consisting of administration of injectable or oral psychotropic medications to a recipient of other mental health rehabilitation services, limited to no more than one visit per week for the initial month, and then no more than 15 visits in any calendar year unless prior approval is granted.

The services above must be specified in an individual plan of care; limits specified in A-F may be exceeded only upon an IDT determination of medical necessity and prior